

**PELTS, KIRKHART**  
ASSOCIATES, LLC

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Phone (504)581-3933 Fax (504)596-3933  
www.pelts-kirkhart.com

**CLIENT FINANCIAL INFORMATION AND AUTHORIZATIONS**

**CLIENT NAME:** \_\_\_\_\_  
Last First Middle Initial

**ADDRESS:** \_\_\_\_\_  
Street and #  
\_\_\_\_\_  
City State Zip

**TELEPHONE:** \_\_\_\_\_  
Home Cell Work

\*Please note the best number for us to call in order to reach you.\*

**EMAIL:** \_\_\_\_\_

**DATE OF BIRTH:** \_\_\_\_\_ **AGE:** \_\_\_\_\_ **SEX:** \_\_\_\_\_

\* \* \* \* \*

**If the client is a minor or another party is to be billed, please complete the following:**

**BILLING INFORMATION**

**RESPONSIBLE PARTY NAME:** \_\_\_\_\_

**RELATIONSHIP TO CLIENT:** \_\_\_\_\_

**BILLING ADDRESS:** \_\_\_\_\_  
(if different) Street and # City State Zip

**TELEPHONE:** \_\_\_\_\_

**EMAIL:** \_\_\_\_\_  
(if different)

**I understand that I am responsible for the cost of treatment. It is my responsibility to contact my insurer to determine coverage. Our office will file claims promptly as a courtesy; however, I and/or my assigned responsible party must pay the unpaid balance.**

\_\_\_\_\_  
Date

\_\_\_\_\_  
Client/Responsible Party Signature

## FINANCIAL POLICY AGREEMENT

We believe that everyone benefits when there is a definite and clear understanding of our financial policy prior to treatment.

1. **ALL** patients are expected to pay in full at the time of service, regardless of your insurance. We will submit claims for your reimbursement as a courtesy at the end of each month.

2. **CANCELLATION POLICY:** There is a broken appointment charge for any patient who cancels with **less than 24 hour** notice or who does not present at the appointed time. You will be charged **100%** of the total missed appointment fee.

**Please Note:** Requests for cancellations or rescheduling of appointments must be done by a representative of the office between 8:30 am and 5:00 pm Monday through Friday. Messages left on the voicemail can't be honored.

3. **NON-SUFFICIENT FUNDS CHECK POLICY:** An NSF fee of \$25 will be charged for all returned checks including any and all bank fees that apply.
4. **SCHOOL OBSERVATIONS** or court-related fees or other services provided out of the office are to be paid in full at the time of the initial appointment or prior to the visit being scheduled.
5. **QUESTIONS:** You are encouraged to call our office if there are any questions about this information. If, at any time during your course of treatment, problems with this financial policy arise, you are encouraged to speak with your clinician or to contact the Office Manager.
6. **A COLLECTION AGENCY** will be engaged if you have an outstanding balance which we have been unable to negotiate or collect.

**For your convenience we accept cash, personal checks, and most major credit cards.**

**I have read and agree with these terms.**

Responsible Party: \_\_\_\_\_ Date: \_\_\_\_\_

Address (if different from patient): \_\_\_\_\_

Name of patient: \_\_\_\_\_

# PELTS, KIRKHART ASSOCIATES, LLC

Client Name: \_\_\_\_\_

Client of: \_\_\_\_\_

## Appointment Reminders

email reminders are sent from

**DoNotReply@myscheduler.net**

(please add address above as an allowed address in your email settings to make sure they are received)

Dear Client,

As a client of Pelts, Kirkhart and Associates, you can receive an appointment reminder to your email address, or your cell phone (via text message when this becomes an option) two days before your scheduled appointments. Any changes to your scheduled appointment must be made by phone prior to 5 pm on the previous business day.

Your email address: \_\_\_\_\_

Your cell phone number: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Your cell phone carrier (circle one):

AT&T      Alltel      Sprint      Boost Mobile      Nextel  
T-mobile      Verizon      VoiceStream      (Other) \_\_\_\_\_

I would like to receive my appointment reminders:

\_\_\_\_ Via email message to the address listed above and

**when available** via text message to my cell phone (normal text message rates will apply)

\_\_\_\_ Via telephone message to my cell (please make sure voicemail is available to leave msg)

\_\_\_\_ None of the above. I'll remember my appointment on my own.  
(Missed appointment fees will still apply)

Appointment information is considered to be "Protected Health Information" under HIPAA. By my signature, I am waiving my right to keep this information completely private, and requesting that it be handled as I have noted above. Appointment reminders are a courtesy offered by Pelts, Kirkhart and Associates with the client being responsible for missed appointments and associated fees.

\_\_\_\_\_  
Client / Parent Signature

\_\_\_\_\_  
Date

**INSURANCE INFORMATION**

**WE WILL NEED A COPY OF YOUR INSURANCE CARD IF INSURANCE IS TO BE BILLED**

DR. \_\_\_\_\_

DR. \_\_\_\_\_

Client name: \_\_\_\_\_

**Insurance Information:**

Subscriber's name: \_\_\_\_\_

Relationship to Client: \_\_\_\_\_

Subscriber's DOB: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Member #: \_\_\_\_\_

Group #: \_\_\_\_\_

Group Name (Employer): \_\_\_\_\_

\*\*\*\*\*

**Please provide the following, if different from client:**

Subscriber's Address: \_\_\_\_\_

Subscriber's Telephone #: \_\_\_\_\_  
Home Cell Work

I authorize the release of any medical or other information necessary to process this claim. **Verification / Prior Authorization of Benefits is client responsibility.**

**PLEASE BRING YOUR INSURANCE CARD OR PROVIDE A COPY**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Responsible Party Signature**